Health Care for the Homeless Network
A Community Project of Public Health—Seattle & King County

2004 Annual Report

Mission:

Health Care for the Homeless Network (HCHN) provides quality, comprehensive health care for people experiencing homelessness in King County, and provides leadership to help change the conditions that deprive our neighbors of home and health.

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Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Acknowledgements

Health Care for the Homeless Network gratefully acknowledges the following for their support:

Health Care for the Homeless Network Planning Council (members listed in Appendix C)

HCHN Contract Partners

- Country Doctor Community Health Centers
- Community Health Centers of King County
- Evergreen Treatment Services
- Odessa Brown Children's Clinic
- Pike Market Medical Center
- Pioneer Square Clinic – Harborview Medical Center
- Puget Sound Neighborhood Health Centers
- Seattle Indian Health Board
- University of Washington Adolescent Medicine
- Valley Cities Counseling & Consultation
- Salvation Army William Booth Center
- YWCA of Seattle-King-Snohomish County

Public Health—Seattle & King County, with particular thanks to the Tuberculosis Control Program; Public Health Clinics; Jail Health Services; Epidemiology, Planning, and Evaluation Section; Emergency Preparedness; and the King County Medical Examiner.

National Health Care for the Homeless Council

Seattle-King County Coalition for the Homeless

HCHN Funders and In-Kind Donations 2004:

- U.S. Department of Health & Human Services, HRSA, Bureau of Primary Health Care
- U.S. Department of Housing & Urban Development
- City of Seattle
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For support in developing the YWCA Opportunity Place Clinic "Third Avenue Center"

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- YWCA of Seattle-King Co.-Snohomish Co.

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A. About This Report

Public Health—Seattle & King County's Health Care for the Homeless Network (HCHN) is pleased to share these highlights of our 2004 work. We hope this information is helpful in supporting our community's efforts to end homelessness in ten years, and that it will stimulate questions and discussions about how to improve clinical services; how to better define and achieve outcomes; and how to be more effective in our work together at a systems level.

Partnerships with community-based agencies constitute the core of the Network. In 2004, HCHN contracted over $3 million to primary care clinics, mental health/substance abuse agencies, and other organizations to sustain a network of staff teams throughout King County who help homeless people access care. Most of these agencies bring added support to the homeless-focused services, and contribute to the Network in a myriad of valuable ways. See page 2 for a list of partner agencies.

Each time a member of the HCH Network sees a client, an HCH "encounter form" is completed. A special client code is used across the network that allows us to unduplicate client data. The HCHN administrative staff compile all data and maintain a database which includes unduplicated client data since 1997.

The data in this report reflect encounter forms completed by about 48 full-time equivalent staff:

- About half are medical staff, predominately nurses with a few nurse practitioners, physician assistants, and doctors.
- About half are other types of staff, including mental health/substance abuse counselors; case managers; outreach/engagement workers; and Medicaid enrollment specialists.

The data presented in this report are drawn from the HCHN database. In the first quarter of 2004, we implemented a revised data collection form, and this report shares the first data from the revised form. **We are particularly grateful to the HCHN staff who take the time and care to complete the encounter forms.**

Public Health—Seattle & King County health care providers also collect information on the housing status of patients seen in most public health clinics and programs. This report includes basic demographic information on homeless clients of Public Health in Appendix A. Further analysis is not included in this report, as the data lives in a different system and a different data collection system is in place. We hope to do more analysis of this data in the future.

Please note: The terms "clients" and "users" are used interchangeably in this report.

Thank you:

- HCHN providers and contractors – *for completing the encounter forms*
- Karen Eckert, HCHN staff – *for database coordination and analysis*
- Betty Helsten, HCHN staff – *for data entry*
- Susan Kline, ARNP, HCHN staff – *for leading encounter form revision process*
- Tom Phillips, One on One – *consultant support for HCHN database*

B. 2004 Major Accomplishments

In 2004, the Health Care for the Homeless Network improved access to and quality of services for people experiencing homelessness. We also focused on TB control, a homeless death review, and long-range planning.

1. Established a new homeless health service site at the YWCA Opportunity Place

In May 2004, Public Health—Seattle & King County's Health Care for the Homeless Network (HCHN) was awarded a $289,000 annualized grant from HHS, Bureau of Primary Health Care. Part of a federal initiative to expand care for the uninsured, the grant establishes nurse practitioner and mental health/substance abuse services at the YWCA Opportunity Place in a small downtown Seattle clinic space called the "Third Avenue Center." Funds are contracted to Harborview Medical Center's Pioneer Square Clinic who staff and operate the new service. The Center targets those with long histories of homelessness and disabling conditions, and one of the goals is to break the cycle of inappropriate use of emergency departments as a source of primary care. Private sector support, *pro bono* professional services and in-kind donations helped launch this important new service.

2. Continued to Provide Access to Health Care

Throughout King County, HCHN contractors provided 41,533 health care visits to over 8,125 unduplicated homeless individuals in 2004. Of the clients, 53% were people of color, and 48% lacked medical coverage of any kind. At least 5,474 referrals made by HCHN workers—referrals to primary or specialty health care, housing, entitlements, and mental health/substance abuse services, for example—were known to have resulted in the client actually receiving needed care. Within Public Health—Seattle & King County, another 13,402 homeless individuals and formerly homeless people received care.

3. Published *Tuberculosis Prevention and Control Guidelines for Homeless Service Agencies*

The TB and Homelessness Coalition—established following the 2002 TB outbreak among homeless people—met quarterly in 2004. This group of homeless agency staff, TB Control Program staff, and Health Care for the Homeless staff developed and endorsed a set of *TB Prevention & Control Guidelines for Homeless Service Agencies* in Seattle-King County, WA. The Guidelines were issued in February 2004. In 2004, the TB Control Program reported 23 cases of active TB among homeless people in King County, compared to 35 cases in 2003, and 30 cases in 2002.

4. Completed a 2003 Homeless Death Review

Working with the King County Medical Examiner Office and the Epidemiology, Planning & Evaluation section, HCHN issued a study of people who died while homeless in 2003. The study identified 77 people; the leading causes of death were acute intoxication, cardiovascular disease, and homicide. The decedents were also found to have high numbers

of various health conditions at the time of their death. The December 2004 study is available on the HCHN website.

5. Adopted a 5-Year Health Care Plan and Business Plan for 2005-2009

As part of its successful application to the federal government for continuation of its project, HCHN developed a five-year Health Care and Business Plan to guide priorities in the years ahead. To inform the work, we conducted a major community survey in April 2004. The Health Care Plan sets goals in the areas of chronic disease management, communicable disease education with homeless agencies, and increasing access to medical, mental health, and substance abuse services.

6. Support for Homeless Agencies - Training and Technical Assistance

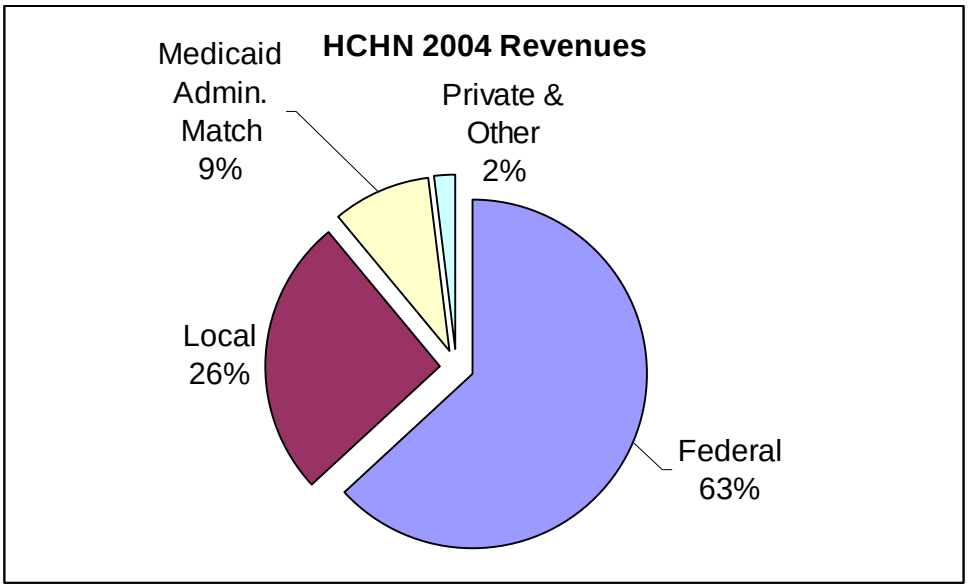
HCHN increased its efforts to promote a healthy and safe environment in homeless shelters, day centers, and housing programs. Through the HCHN Health & Safety Project, over 50 major health education workshops and agency consultations were held, and dozens of professional consultations took place with community partners needing information about homelessness and health. Workshops were held on emergency preparedness for homeless agencies, tuberculosis, and on death and dying. Over 600 homeless people received flu shots at 33 homeless program sites.

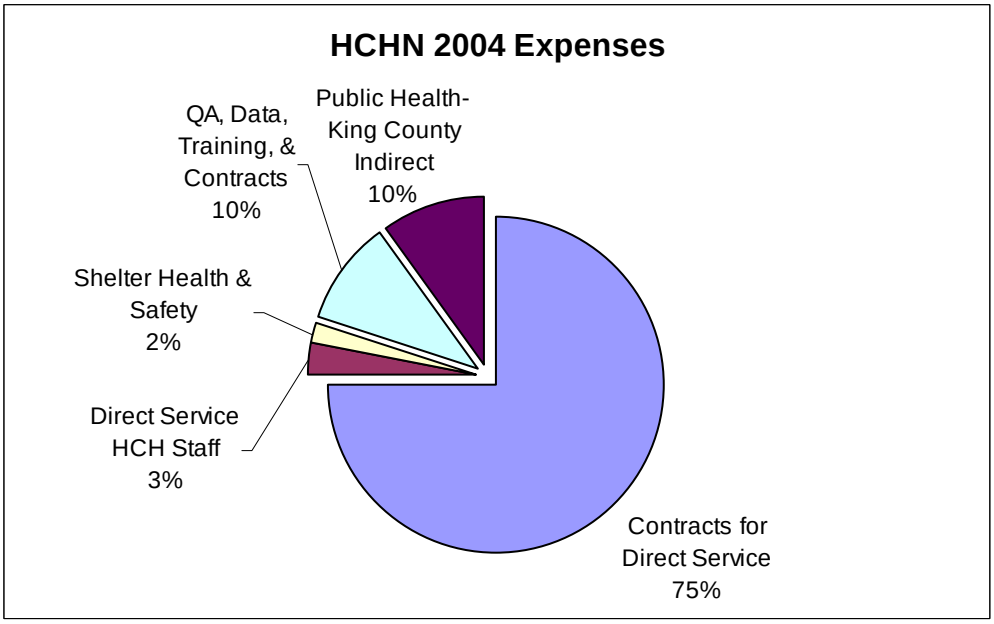
7. Advocacy & System Improvements

In 2004, HCHN participated actively in the Committee to End Homelessness in King County, the Safe Harbors Advisory Committee, the Chronic Populations Action Council, and the Taking Health Care Home Initiative. We briefed the King County Board of Health on HCHN activities, helped convene community workshops to spread the word about the transformation of GA-U medical to a managed care program, and were active in leadership positions with the National Health Care for the Homeless Council.

C. Program Resources 2004

The HCHN program budget for 2004 was $4.3 million. Most revenue is federal – a combination of Health & Human Services (HHS) and Housing & Urban Development (HUD). The HUD funds are designated for two specific projects – the Pathways Home case management for families, and the Medical Respite program. HHS funds are allocated according to the annual application and plan submitted to HHS-Bureau of Primary Health Care.





D. HCHN Major Service Sites 2004 – Contracted Services

Through contract partnerships with health, mental health, substance abuse, and other organizations, HCHN supports geographic-based teams of nurses, counselors, and Medicaid eligibility specialists that provide assistance in selected homeless sites throughout King County. Due to limited resources, services vary by site and are not available in all homeless programs. In addition, three special programs receive support through HCHN, and are detailed further in Section F of this report: Pathways Home, REACH case management, and the Medical Respite program.

Sites with regular health services supported—in whole or in part, depending on the site—by Health Care for the Homeless Network:

Single Adults

Chief Seattle Club
Compass Center & Compass Cascade
Downtown Emergency Service Center
Downtown YWCA
Dutch Shisler Sobering Support Center
St. Martin de Porres Shelter
Salvation Army William Booth Center
Katherine's House
Second Avenue Clinic (co-located with Needle Exchange)
Third Avenue Center (at YWCA Opportunity Place)

Unattached Youth

45th Street Clinic (Puget Sound Neighborhood Health Centers)
County Doctor Youth Clinic (via UW Adolescent Medicine clinic)
Eastside Community Youth Clinic (Community Health Centers of King County)
YouthCare Orion Center
YMCA The Landing Teen Shelter (Bellevue)

Families

Broadview Shelter – FPA
Catherine Booth House – Salvation Army
Community Health Centers of King County
Domestic Abuse Women's Network
Eastside Domestic Violence Program
First Place School
Hopelink sites
Jubilee House
South King County Multi-Service Center sites
YWCA family sites countywide
New Beginnings
Our Place Day Care
Providence Hospitality House
Rose of Lima
Sacred Heart
Seattle Emergency Housing Services (YWCA)
Union Gospel Mission Family Shelter
Morningsong Family Support Center
Family & Adult Service Center

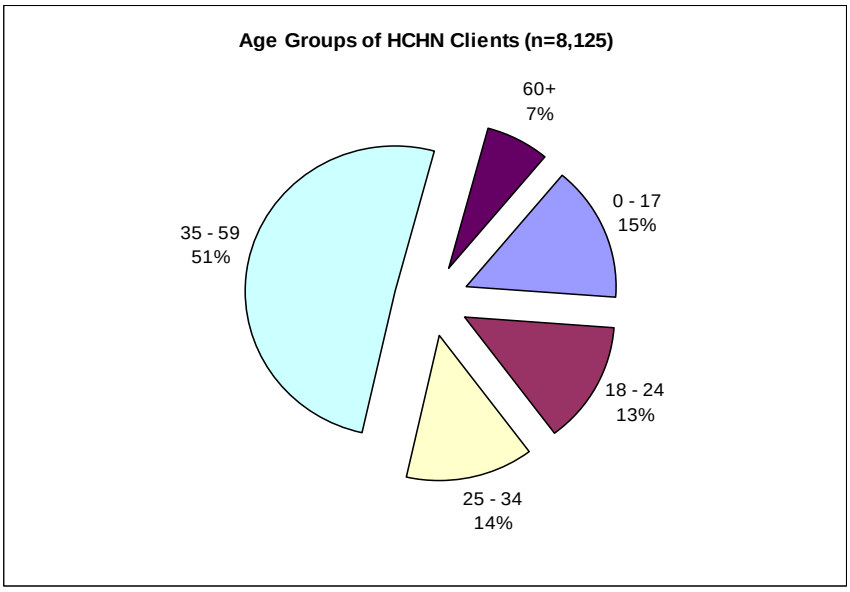
Certain visits also take place in the client's home (once housed), streets, encampments, and other sites.

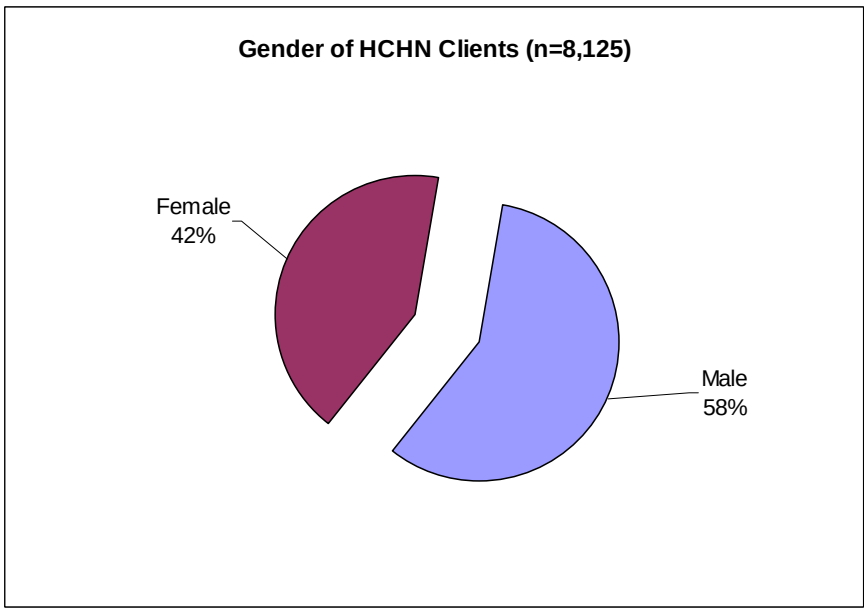
E. Summary Data – HCHN Contracted Services

This section provides information on the 8,125 unduplicated homeless people seen through HCHN contracted services. Most services took place in homeless agency sites and homeless-focused clinic sites.

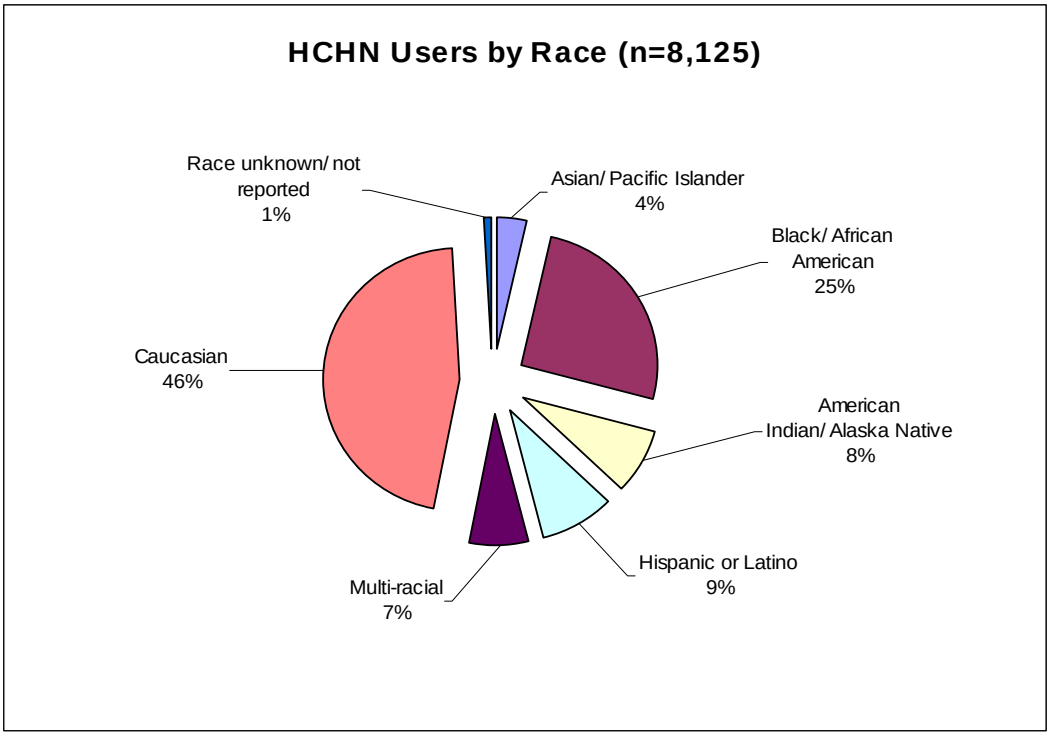
1. HCHN Client Demographics

Age, gender, race, and household information are shown below. Please keep in mind this is reflective of the types homeless sites at which services are provided.

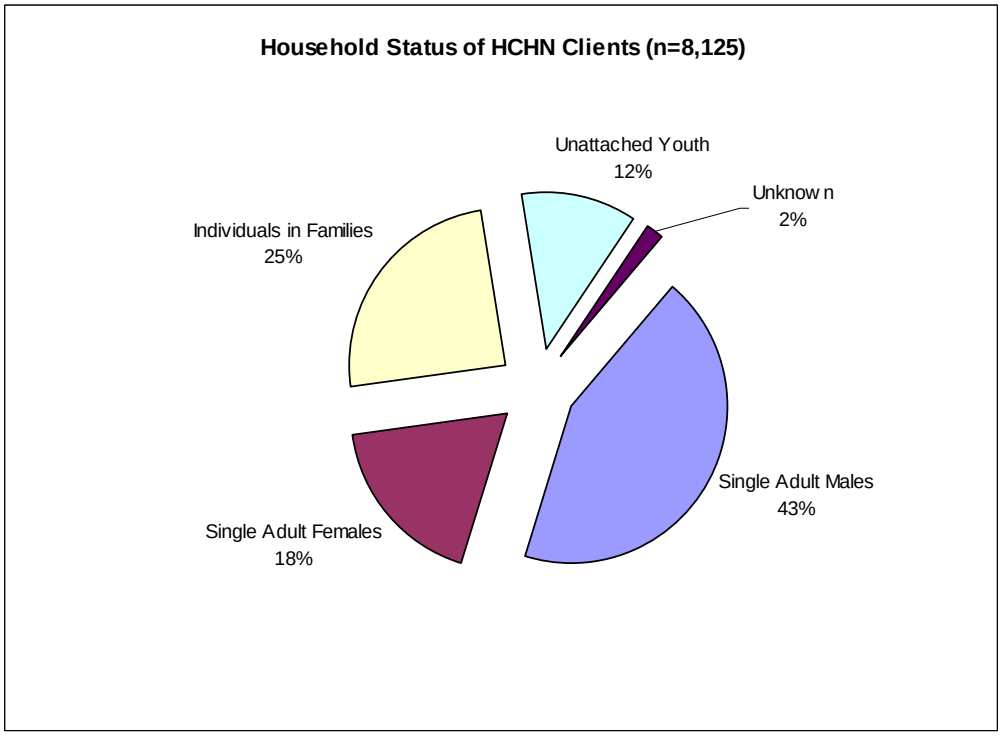




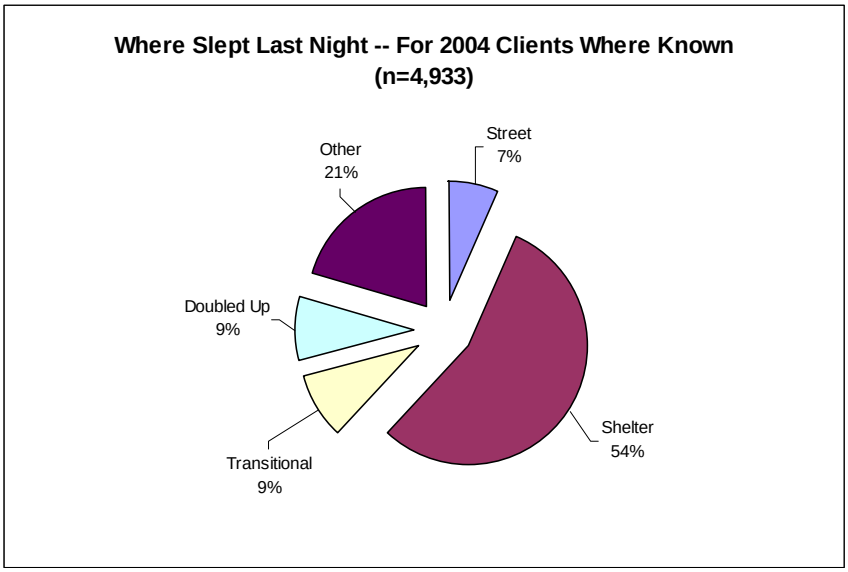
Similar to the overall homeless population of King County, over half of all HCHN clients are people of color:



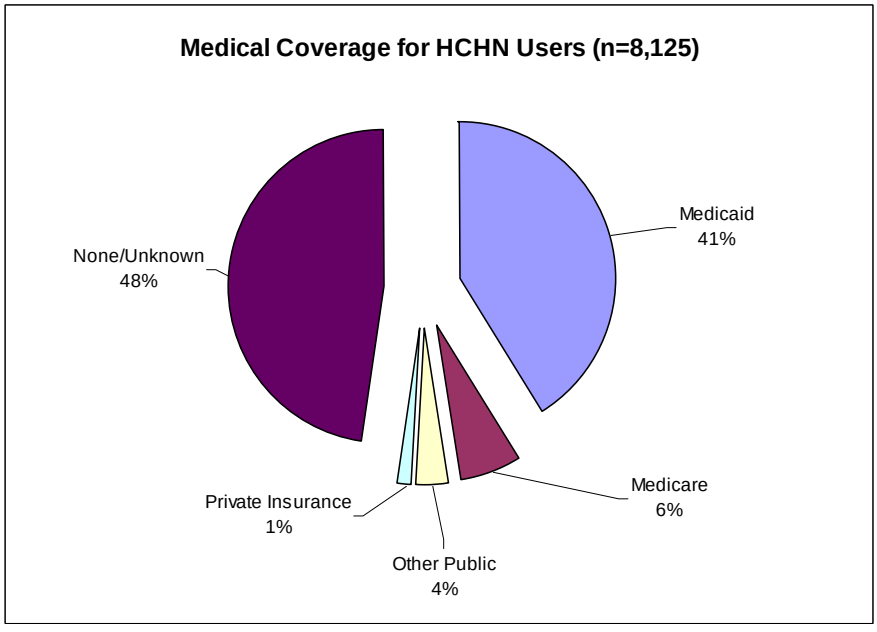
Of HCHN 2004 clients, the largest group was single adults (61%).



For 4,933 HCHN clients seen in 2004, we had information on where the individual slept the previous night. Most clients stayed in shelter, reflective of our shelter-based service model. "Other" includes locations such as hospitals, jails, the Medical Respite program, motels, and other unstable housing situations. It also includes those who were recently housed but still receiving HCHN services.



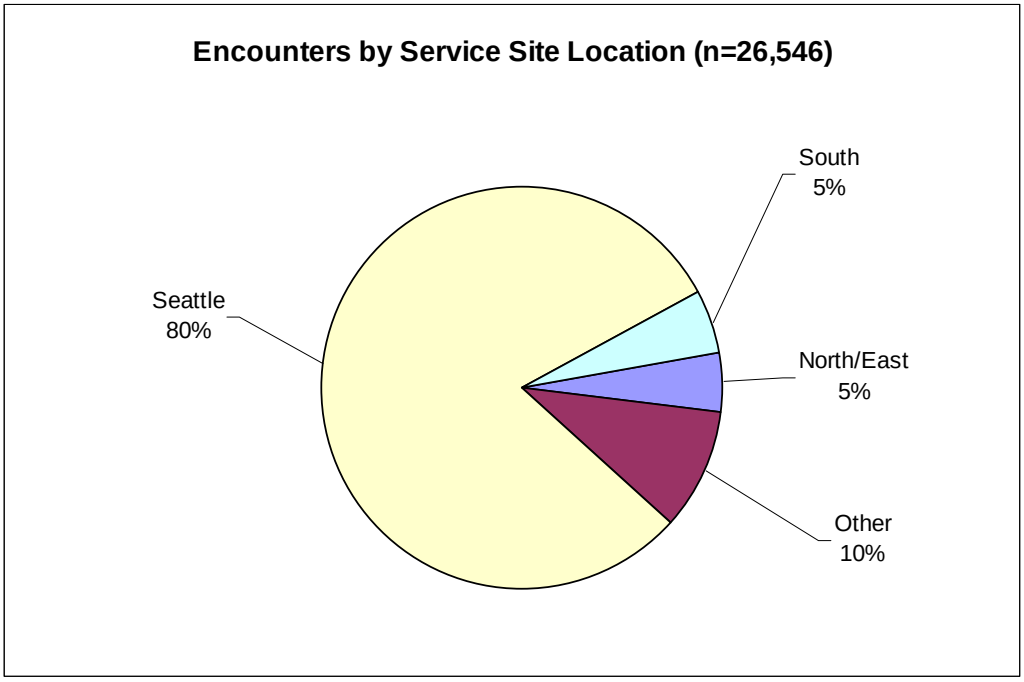
HCHN users tend to either be uninsured or covered through Medicaid, the federal health program for low-income people. Medicaid is available mainly to families with children and people with disabilities. "Other Public" are state-only programs such as General Assistance and the Basic Health Plan.



2. Geographic Location of Services

The following shows the subregion of King County where the service encounters in homeless agency sites took place. This display excludes clinic-based encounters. Please keep in mind this reflects where the service took place, and is not necessarily reflective of need. "Other" are site code locations (such as client's home, street, and others) that do not have a geographic subregion associated with the code.

The high percentage of encounters in Seattle reflects various dynamics including: (1) the majority of homeless persons and shelters are located in Seattle; (2) the presence of large HCHN programs such as Medical Respite and REACH in Seattle; (3) nurses sited at large single adult shelters typically are able to see more individuals on a given day than a nurse working in suburban areas, where travel and other program differences are factors; and (4) City of Seattle investments in HCHN have allowed for more services for Seattle's homeless population. Need and demand for expanded HCHN services in south and east King County are high.



3. Veteran Status

In 2004, HCHN provided services to 355 unduplicated homeless veterans. HCHN staff attempt to link eligible veterans to services available to them through the VA and related programs.

ALL HCHN CLIENTS		
Veterans--Unduplicated Users	355	
Vietnam Era (subset of the 355)	108	
% of Total Veterans	30%	
Gender		
Female	29	
Male	326	
Household Status		
Individual	335	
Family	18	
Unknown	2	
Race		
American Indian/Alaska Native	35	10%
Asian/Pacific Islander	4	1%
Black	96	27%
Hispanic (all races)	9	3%
Multi-Racial	22	6%
Other	5	1%
White	184	52%
Total	355	100%

At what HCHN service sites were homeless veterans most commonly seen?
The highest number of HCH visits provided to homeless veterans were at the sites listed below—not surprisingly, sites serving homeless single men topped the list. The visits in homeless sites were primarily nursing or mental health/substance abuse visits, plus some nurse practitioner/physician assistant visits.

# of Visits	Site
1172	Men's Medical Respite Program (at William Booth Center)
443	St. Martin de Porres Shelter
421	Downtown Emergency Service Center (DESC)
412	REACH Case Management Team (at Sobering Center)
266	Pioneer Square Clinic
128	Occasional Sites
82	Client's Home
40	Street, Alleys, Parks etc.
32	Second Avenue Clinic (Pioneer Square Clinic) – at Needle Exchange
32	Women's Medical Respite Beds - at YWCA Angeline's
28	Angeline's Day Center
21	Broadview Emergency Shelter
20	Chief Seattle Club

For what health problems were homeless veterans most commonly seen?

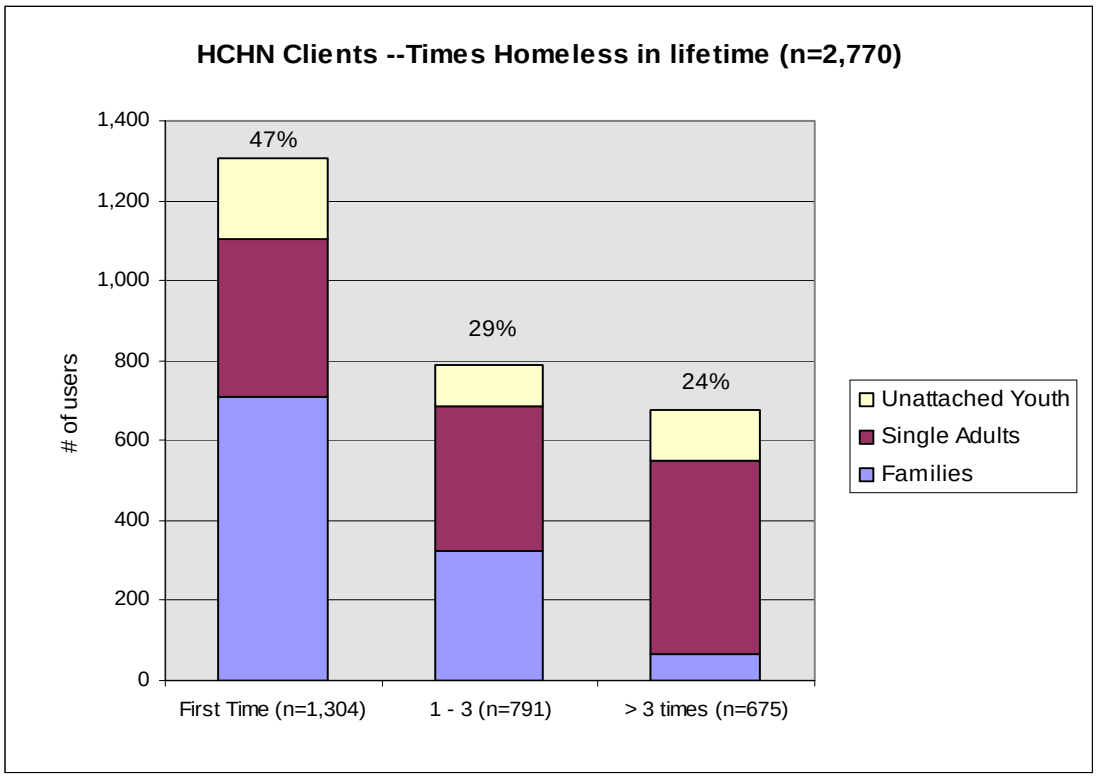
# of Visits	Body System
1,602	Substance Abuse Related
1,026	Mental Health (see below)
913	Skin conditions (includes cellulitis & abscesses)
613	Cardiovascular
426	Gastrointestinal
398	Musculoskeletal
384	Respiratory
304	Endocrine
111	Nutrition
66	No Problem Identified / Screening
40	Neurological
23	Genitourinary

# Visits	*Mental Health breakout*
114	Anxiety
276	Depression
527	Mental Health-Other
109	Psychoses

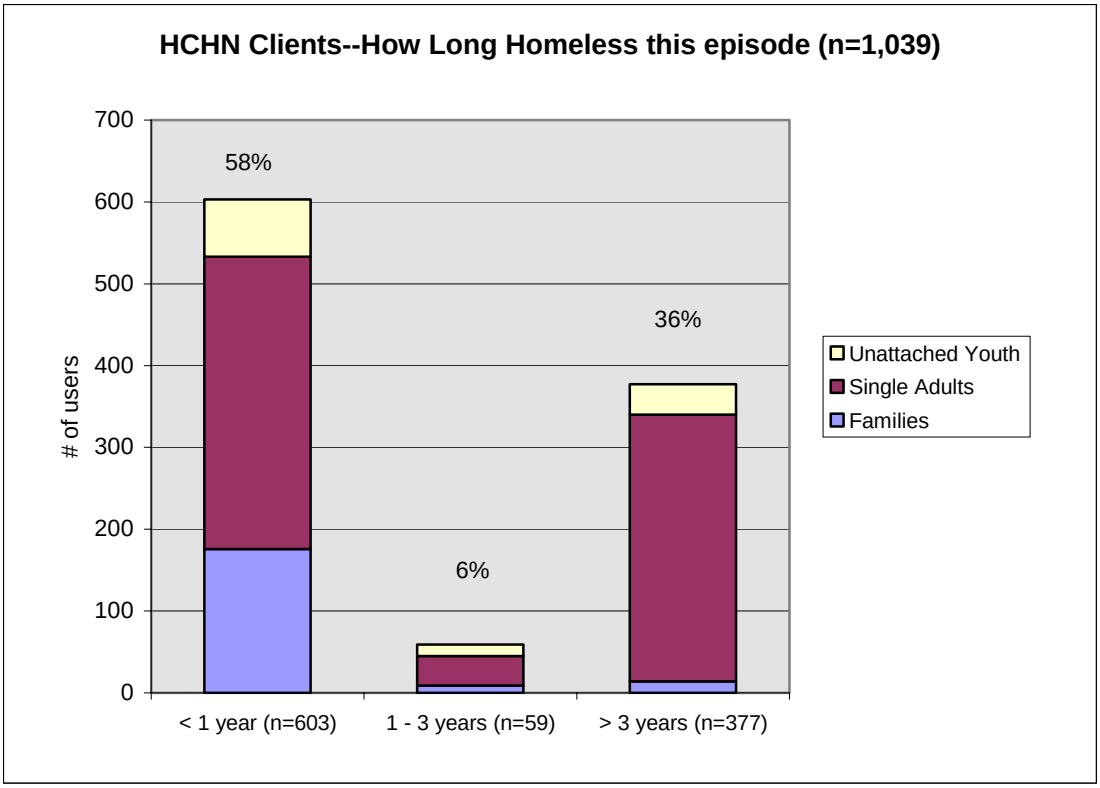
4. History and Length of Homelessness

In 2004, HCHN began collecting information on the client's history of homelessness. Providers were asked to acquire that information when *feasible*, so it is reported below only for the clients who were able or willing to share the information with us. We asked two questions: (1) Length of time of the current episode of homelessness? and (2) Number of instances of homelessness over the years? We used the same categories of data collection that were already in use by the Medical Respite program. Those categories were set as part of the national respite pilot site evaluation project, in which the Seattle-King County Medical Respite program is a participant.

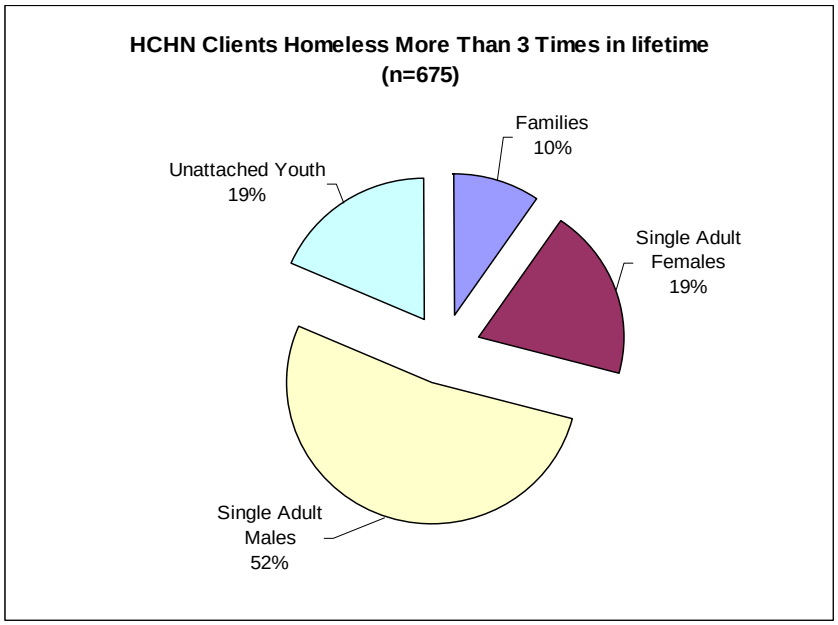
Episodes of homelessness. For 47% of HCHN clients for whom the information was known, this was their first episode of homelessness. Among that group, the majority were individuals in families. Of 675 individuals who had been homeless more than 3 times, the majority were single adults.

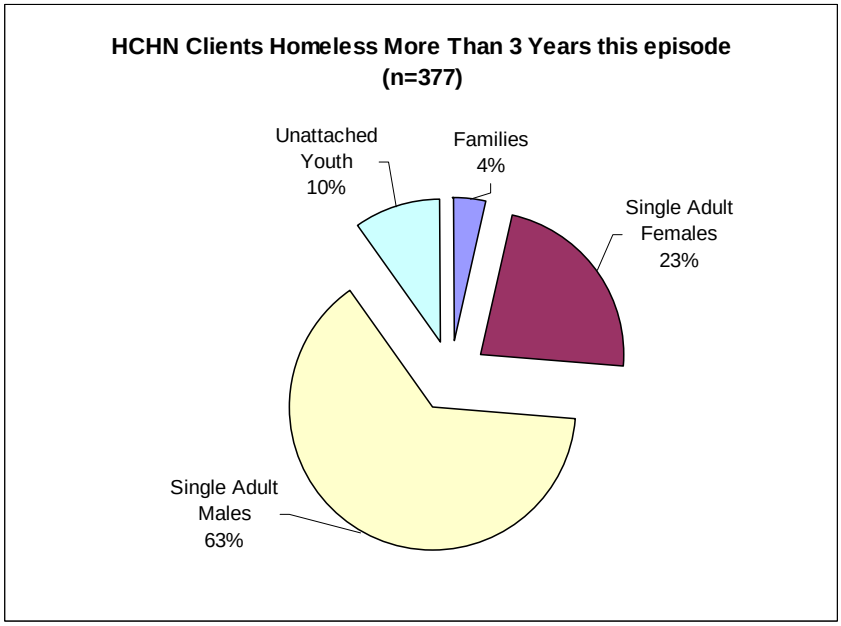


Length of current episode of homelessness. Of the HCHN clients for who information on length of time homeless was known, 58% of them had been homeless less than one year. Of those who had been homeless more than 3 years, the majority were single adults.



Household status of those with longest histories of homelessness. Consistent with national data on homeless people, HCHN clients who were single adults had longer and more frequent episodes of homelessness than families or youth. However, all three subpopulations did have clients with long histories of homelessness. (It is also possible that we had easier access to the data for single adults than for other groups due to the Respite program's history and experience in collecting the data.)





5. Health Problems and Social Issues

The most common health problems of HCHN clients remain similar to those seen in past years, and reflect the harshness of life on the streets and in shelters, as well as underlying causes of homelessness. Skin conditions, upper respiratory infections, mental health and substance abuse problems, and cardiovascular problems are among the problems most frequently seen.

Appendix B includes information on the specific health problems by subpopulation. The table below lists the five most common health problems seen by medical care personnel (nurses, nurse practitioners, doctors, and physician assistants).

Most Common Health Problems 2004 – Seen by Medical Staff (excludes signs & symptoms and social issues)

Rank	Single Women	Single Men	Family Adults	Family Children	Unattached Youth
1	Skin conditions	Skin conditions	Mental Health	Health maintenance	Health Maintenance
2	Respiratory	Musculoskeletal	Musculoskeletal	Respiratory	Screening/No Problem
3	Mental Health	Respiratory	Dental	Skin	Respiratory
4	Musculoskeletal	Substance Abuse Related	Cardiovascular	Screening/No Problem	Skin conditions
5	Substance Abuse Related	Cardiovascular	Respiratory	Mental health	Mental health

Skin conditions run as a common thread among the population groups. For children, eczema, diaper rash, fungal conditions, and impetigo[1] are common problems. Among adults, cellulitis (a skin infection which left untreated can spread), abscesses (often related to intravenous drug use), and lice and scabies are common problems.

Respiratory conditions in the homeless population frequently include the common cold, acute and chronic bronchitis, sinusitis, and asthma. Musculoskeletal conditions include a broad range of problems such as arthritis, back pain, and foot and shoulder problems among many others.

For children and youth, health maintenance refers to visits where services such as well child checks, health education, and immunizations take place. Screening/no problem means that a nurse did a general health screening but identified no problems or services needed.

[1] A contagious bacterial infection of the superficial layer of the skin. The bacteria usually infect skin that has been damaged by scratching an insect bite or picking a scab.

Number and % of HCHN clients with specific health issues

		% of total users with this condition
Signs & symptoms (see breakdown below)	2,964	36%
Mental Health issues (see breakdown below)	2,849	33%
Skin conditions	1,691	21%
Substance Abuse Related	1,539	19%
Respiratory conditions	1,380	17%
Musculoskeletal	1,294	16%

In 2004, we created new fields on the HCHN Encounter Form to record signs and symptoms, since nurses do not make medical diagnoses. When a client reports a specific, known health condition to the nurse (such as "I have diabetes") the nurse or counselor can and does record that diagnosis on the encounter form.

Most common signs & symptoms include:

Sign or symptom	***# of Users***
Emotional/adjustment/situational issue	601
Upper respiratory symptoms	446
Skin wound	284
Sleep disturbance	222
Cough	215
Fatigue	213
All other signs & symptoms	983
Total	**2964**

Mental health issues include:

Issue	***# of Users***
Depression	1,042
Anxiety	534
Psychoses	150
All other mental health	1,123
Total	**2849**

Chronic Health Problems. In 2004, HCHN began collecting information about known chronic health conditions of clients, in addition to the reason(s) for the client's visit (which may be different). The most common chronic conditions reported were:

(1) depression and other mental health problems
(2) substance abuse related conditions
(3) respiratory conditions; and
(4) cardiovascular conditions

Social Issues/Needs. During each visit with an HCHN Provider, the client is assessed for other pressing, unaddressed social issues related to their homelessness.

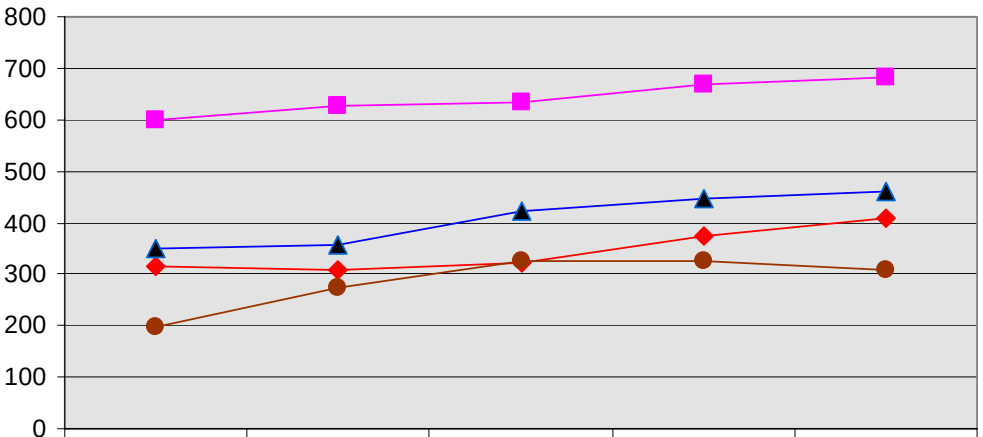
Top Issues	**# of Users**
Housing needs	1,292
Problems with access to health care coverage/Medicaid	558
Primary Health Care Provider Needed	508
Parenting Issues	400
Situational/Interpersonal	385
Domestic Violence	380
Entitlement/Benefits	351

6. Changes in Selected Health Problems

The number of HCHN users with diabetes, asthma, and hypertension increased in 2004 over 2003 levels. These trends have promoted a special "chronic care initiative" by the HCH Network in 2005 to better address and manage chronic health conditions among homeless people.

Number of HCH Users With Selected Problems, 2000-2004

Note: # of users each year remained constant at about 8,000 people



	2000	2001	2002	2003	2004
Asthma	316	309	321	373	410
Hypertension	599	627	634	667	681
Diabetes	351	355	424	446	459
Nutrition Problem	196	273	324	326	307

7. Referrals Made and Completed

When an HCHN provider sees a homeless individual and makes a referral for that client to another service, this is indicated on the encounter form. If the HCHN provider later knows whether the client followed through or not, the information is updated to indicate whether the client received care, did not receive care, was lost to follow up, or unknown. Because homeless people move frequently, many clients are only seen once while in a shelter stay and the HCHN provider has no way of knowing whether follow-up on a given referral took place.

We know that, at a minimum, over half of all referrals made by HCHN providers resulted in care actually being received by the client.

Total Referrals Made in 2004 (all types): 9,982
Care Received: 5,474 (55%)

Most Common Referrals Made (top 10)

Referral Made to:	Number of Referrals Made
Primary Care Provider	2,739
Social Services Agency[2]	1,577
Community Substance Use Treatment Services	1,095
Community Mental Health/Counseling Services	992
Housing	968
Specialty Medical Care	738
Dental Services	512
Hospital/Emergency Room/Urgent Care	370
DSHS	335
Vision Services	249

Referral Completion

The following tables show the referral types and what we know about whether clients followed through and received care. Interpretation of this data is difficult: it may, for example, be possible that for certain types of referrals (such as referrals to medical care), the HCHN provider is more likely to know the outcome than for other types of referrals (such as referrals to housing or employment). Also, some types of referrals can be acted upon quickly, while others take months or years (waiting lists) for care to actually be received. Taken as a whole, however, the information echoes anecdotal reports from HCHN providers – that medical care and substance

[2] This line combines several referral categories including financial assistance, entitlements, clothing, food, legal assistance, parenting resources, household items, hygiene services, and others.

abuse services can often be arranged for motivated clients, while mental health services, housing, and dental care are generally more difficult for people to access.

Referrals Made Where Over Half Were Known to Have Received Care

	Total Referrals	Known to Receive Care	Percent of Completed Referrals
Public Health – TB Control Program	48	38	79.17%
Community Substance Use Treatment Services	1095	820	74.89%
Social Services Agency	1577	1132	71.78%
Specialty Medical Care	738	525	71.14%
Hospital/Emergency Room/Urgent Care	370	228	61.62%
Primary Care Provider	2739	1384	50.53%
DSHS	335	169	50.45%

Referrals Made Where Fewer than Half Were Known to Have Received Care

	Total Referrals	Known to Receive Care	Percent Completed Referrals
Community Mental Health/Counseling Services	992	466	46.98%
Vision Services	249	111	44.58%
WIC & Nutrition Services	111	49	44.14%
Housing	968	365	37.71%
Disability Evaluation	24	9	37.50%
Employment/Vocational Services	75	28	37.33%
Education Services	19	6	31.58%
Birth to 3/Special Education	19	5	26.32%
Dental Services	512	90	17.58%

The information above will be shared with the HCHN Quality Management committee and the HCHN providers for discussion and follow-up.

F. Program Updates 2004

1. Pathways Home Case Management for Homeless Families

Pathways Home provides intensive case management to homeless families throughout King County, and targets those where at least one major health issue is present. Contract partners are Valley Cities Counseling & Consultation and Puget Sound Neighborhood Health Centers, who form multidisciplinary staff teams that work with families on resolving health issues and accessing stable housing. Referrals are made through intake services at Valley Cities Counseling & Consultation, and the team can carry a caseload of 45 families at any given time.

In 2004 operating year (February 1, 2004 – January 31, 2005):

- 93 homeless families—comprising 335 individuals—received Pathways Home services.
- Of 48 adults in families who entered the project during that year, 24 of them (50%) had a psychiatric diagnosis.

Race/Ethnicity of Pathways Home participants

	Total	Percent
American Indian/Alaska Native	15	4%
Asian/Pacific Islander/Native Hawaiian	4	1%
Black	102	31%
Hispanic (all races)	17	5%
Multi-Racial Other	39	12%
White	155	46%
Other	3	1%

Selected Outcomes
Pathways Home focuses on moving families into permanent housing, addressing underlying physical and behavioral health issues of both the children and adults, and linking families to mainstream health care and other supports.

- 30% of families served by the Pathways Home therapeutic team moved into permanent affordable housing between program intake and discharge (goal is 20%).
- 87% of families were evaluated for appropriate income and assistance sources at the time of intake (goal is 85%).
- 100% of families assessed to be eligible for mainstream services and not yet receiving benefits were assisted in completing appropriate applications (goal is 80%).

2. REACH Case Management for Chronic Public Inebriates

REACH provides 7.5 full-time equivalent case managers and one nurse at the Dutch Shisler Sobering Support Center to engage chronic public inebriates in case management and housing. HCHN contracts with Evergreen Treatment Services and Pike Market Medical Clinic for the program, which is funded with local revenues. REACH uses motivational interviewing and goal-directed care plans to engage clients in substance abuse treatment, health care, and housing.

REACH Clients 2004

- Provided case management to 150 individuals. Of these, 26 were new clients first engaged in 2004 and 123 were clients initially engaged in previous years.
- 79% of REACH 2004 clients were male; 21% were female.
- Case managers carry a caseload of about 20, and they target the highest utilizers of the Sobering Center. Since 1998, 63% to 78% of the "top 60" sobering utilizers of each year were engaged in REACH case management.

Race/ethnicity of REACH Clients

Native Americans constitute 38% of all REACH clients, but are just 4% of the overall homeless population of King County, based on the One Night Count of the Seattle-King County Coalition for the Homeless.

Race	Percent
American Indian/Alaska Native	38%
Asian/Pacific Islander	0%
Black	10%
Hispanic (all races)	8%
Multi-Racial Other	2%
White	42%
Total	100%

Selected Outcomes

- 67% of REACH clients participated in substance abuse treatment in 2004 (Goal is 30%).
- Of new clients engaged in services in 2004, 46% improved their housing stability (Goal is 40%). Including both new and continuing clients, 75% improved or maintained housing stability.
- Of new clients engaged in services in 2004, 62% improved their income situation (goal is 50%).

3. Medical Respite (Recuperation Beds for Homeless Adults)

Medical Respite provides 22 beds and daily nursing care for homeless single adults who need a place to recuperate from an acute illness. Most clients access a Respite bed upon discharge from Harborview Medical Center or other health care settings, making this program a critical resource in discharge planning. Beds for men are at the Salvation Army William Booth Center, and for women at the YWCA Angeline's program. Respite clients access a full psychosocial assessment, social work, and housing linkage services. Harborview Medical Center's Pioneer Square Clinic operates the program under contract with HCHN. The program is one of 28 Medical Respite programs for homeless people nationally, and the Seattle-King County program is one of ten sites participating in a national evaluation.

In 2004 operating year (February 1, 2004 – January 31, 2005):

- 394 homeless people had a stay in the Medical Respite program
  - 275 (70%) of them met the federal definition of chronically homeless[3]
  - 310 (79%) had a disability
  - 85 (22%) were veterans

Medical Respite clients with special needs:

	All Respite Clients	Chronically Homeless Respite Clients
Mental Illness	54%	61%
Alcohol Abuse	49%	57%
Drug Abuse	57%	67%
HIV/AIDS	1.5%	1.5%

Top Five Primary Admitting Diagnoses (what acute health condition qualified them for a Respite stay):

Primary Admitting Diagnosis	Number of clients	% of all admits
Abscesses, cellulitis, ulcers, or infection	149	38%
Need for post-surgical care	67	17%
Pneumonia	30	8%
Fracture	25	6%
Diabetes	16	4%

[3] HUD defines a chronically homeless person as "an unaccompanied homeless individual with a chronic disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past 3 years.

Race/ethnicity of Respite clients

Race	Total	Percent
American Indian/Alaska Native	18	5%
Asian/Pacific Islander/NH	12	3%
Black	106	27%
Hispanic (all races)	30	8%
Multi-Racial Other	23	6%
White	195	48%
Other/Unknown	10	3%
Total	394	100%

Selected Outcomes

Medical Respite engages homeless people with some of the most serious combinations of physical and behavioral health problems in our community. The majority—70 percent—have long histories of homelessness. Many are actively using drugs/alcohol and not using shelter services. Despite this, many clients make significant strides toward stability as a result of a Respite stay.

- 46% of clients (186 out of 394) completed their recommended respite stay and resolved their presenting medical problems. (Goal is 40%)

- 41% (76) of the 186 clients who completed their recommended Respite stay obtained an improved housing situation upon exit. (Goal is 35%)

- 93% of the targeted respite clients (319 out of 342 who stayed in the program 3 or more days and did not have a case manager) received a psycho-social assessment. (Goal is 35%) Of those 319, 63% of them were successfully linked to at least one of the identified needed services for that client. (Goal is 50%).

Appendix A – Demographics

2004 Health Care for the Homeless Demographic Summary

	Contracted	Public Health	Total
Total Encounters	41,533	45,368	86,901
Unduplicated Clients	8,125	13,402	21,527

	HCHN Contracted		Public Health Sites		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
AGE						
0-5	487	6%	3,780	28%	4,267	20%
6 through 10	230	3%	300	2%	530	2%
11 through 13	121	1%	148	1%	269	1%
14 through 17	389	5%	811	6%	1,200	6%
18 through 24	1,095	13%	3,294	25%	4,389	20%
25 through 34	1,120	14%	2,457	18%	3,577	17%
35 through 59	4,126	51%	2,401	18%	6,527	30%
60 through 74	510	6%	194	1%	704	3%
75 through 84	45	1%	16	0%	61	0%
85+	2	0%	1	0%	3	0%
Total	**8,125**	**100%**	**13,402**	**100%**	**21,527**	**100%**
RACE/ETHNICITY						
Asian/Pacific Islander	299	4%	1,265	9%	1,564	7%
Black	2,066	25%	2,494	19%	4,560	21%
American Indian/AK Native	664	8%	573	4%	1,237	6%
Hispanic or Latino	717	9%	2,707	20%	3,424	16%
Multi-racial	576	7%	637	5%	1,213	6%
People of color total	*4,322*	*53%*	*7,676*	*57%*	*11,998*	*56%*
Caucasian	3,744	46%	4,765	36%	8,509	40%
Race unknown or not reported	59	1%	961	7%	1,020	5%
Total - all race	**8,125**	**100%**	**13,402**	**100%**	**21,527**	**100%**
GENDER						
Male	4,690	58%	4,809	36%	9,499	44%
Female	3,435	42%	8,593	64%	12,028	56%
Total	**8,125**	**100%**	**13,402**	**100%**	**21,527**	**100%**
HOUSEHOLD TYPE/SOCIAL UNIT						
Family	2,016	25%			2,016	25%
Individual	5,010	62%			5,010	62%
Unattached Youth	969	12%			969	12%
Unknown	130	2%			130	2%
Total	**8,125**	**100%**			**8,125**	**100%**
HOUSING STATUS						
Street	332	4%	544	4%	876	4%
Shelter	2,705	33%	1,720	13%	4,425	21%
Transitional	455	6%	803	6%	1,258	6%
Doubled Up	429	5%	6,754	50%	7,183	33%
Other	1,012	12%	3,574	27%	4,586	21%
Unknown	3,192	39%	7	0%	3,199	15%
Total	**8,125**	**100%**	**13,402**	**100%**	**21,527**	**100%**
INSURANCE						
Medicaid	3,351	41%	7,286	54%	10,637	49%
No insurance or unknown	3,876	48%	5,888	44%	9,764	45%
Other Public Insurance	291	4%	17	0%	308	1%
Medicare	499	6%	105	1%	604	3%
Private Insurance	108	1%	106	1%	214	1%
Total	**8,125**	**100%**	**13,402**	**100%**	**21,527**	**100%**

Single Adult Females -- 2004 Users With Given Problem

(A user may have more than one problem)

1,381 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	143	7	483	6	3.4	2
Dental	34		50		1.5	13
Disability	12		14		1.2	17
Endocrine	102	9	420	7	4.1	1
Gastrointestinal	85	10	234	9	2.8	6
Genitourinary	82		127		1.5	13
Health Maintenance	37		52		1.4	15
Immune	2		6		3.0	4
Kidney	6		6		1.0	19
Musculoskeletal	238	4	509	4	2.1	10
Neurological	34		87		2.6	7
No Prob/Screen	126	8	170	10	1.3	16
Nutrition	42		107		2.5	8
Respiratory	259	2	488	5	1.9	11
Skin	301	1	864	1	2.9	5
Social Issue	169	6	277	8	1.6	12
Substance Related	203	5	668	2	3.3	3
Trauma	14		15		1.1	18
Mental Health	255	3	608	3	2.4	9
Anxiety	40		47		1.2	
Depression	143		288		2.0	
Mental Health-Other	100		235		2.4	
Psychotic	20		38		1.9	
Sign/Symptom	521		1,055		2.0	
Other	389		781		2.0	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	143	7	483	7	3.4	4
Dental	34		50		1.5	13
Disability	19		27		1.4	16
Endocrine	102	9	420	8	4.1	3
Gastrointestinal	85	10	234	9	2.8	8
Genitourinary	82		127		1.5	13
Health Maintenance	38		53		1.4	16
Immune	2		6		3.0	5
Kidney	6		6		1.0	19
Musculoskeletal	238	6	510	5	2.1	11
Neurological	34		87		2.6	9
No Prob/Screen	132	8	177	10	1.3	18
Nutrition	42		107		2.5	10
Respiratory	259	5	489	6	1.9	12
Skin	302	4	865	4	2.9	6
Social Issue	449	1	1,295	3	2.9	6
Substance Related	320	3	1,627	2	5.1	2
Trauma	43		65		1.5	13
Mental Health	419	2	2,358	1	5.6	1
Anxiety	127		450		3.5	
Depression	245		903		3.7	
Mental Health-Other	203		772		3.8	
Psychotic	61		233		3.8	
Other	472		1,103		2.3	
Sign/Symptom	584		1,260		2.2	

Single Adult Males -- 2004 Users With Given Problem

(A user may have more than one problem)

3,164 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	532	5	2,572	3	4.8	5
Dental	19		21		1.1	16
Disability	16		16		1.0	18
Endocrine	355	8	2,261	4	6.4	2
Gastrointestinal	275	9	1,411	8	5.1	4
Genitourinary	127		314		2.5	12
Health Maintenance	43		48		1.1	16
Immune	21		86		4.1	7
Kidney	12		38		3.2	10
Musculoskeletal	650	2	2,150	5	3.3	9
Neurological	103		241		2.3	13
No Prob/Screen	473	6	645	9	1.4	14
Nutrition	107		399	10	3.7	8
Respiratory	620	3	1,682	7	2.7	11
Skin	948	1	4,123	1	4.3	6
Social Issue	179	10	218		1.2	15
Substance Related	563	4	3,677	2	6.5	1
Trauma	3		3		1.0	19
Mental Health	390	7	2,108	6	5.4	3
Anxiety	32		68		2.1	
Depression	250		936		3.7	
Mental Health-Other	156		760		4.9	
Psychotic	43		344		8.0	
Other	932		3,173		3.4	
Sign/Symptom	1,003		2,367		2.4	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	532	7	2,572	4	4.8	5
Dental	19		21		1.1	17
Disability	23		33		1.4	15
Endocrine	355	9	2,261	5	6.4	3
Gastrointestinal	275	10	1,411	9	5.1	4
Genitourinary	127		314		2.5	13
Health Maintenance	49		54		1.1	17
Immune	21		86		4.1	7
Kidney	12		38		3.2	11
Musculoskeletal	650	3	2,151	6	3.3	10
Neurological	107		256		2.4	14
No Prob/Screen	477	8	652	10	1.4	15
Nutrition	107		401		3.7	8
Respiratory	621	4	1,683	8	2.7	12
Skin	948	1	4,124	2	4.4	6
Social Issue	615	5	2,141	7	3.5	9
Substance Related	797	2	6,591	1	8.3	1
Trauma	8		8		1.0	19
Mental Health	541	6	4,110	3	7.6	2
Anxiety	79		366		4.6	
Depression	327		1,686		5.2	
Mental Health-Other	324		1,623		5.0	
Psychotic	64		435		6.8	
Other	1,180		4,588		3.9	
Sign/Symptom	1,037		2,473		2.4	

Children in Families -- 2004 Users With Given Problem

(A user may have more than one problem)
885 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	1		1		1.0	17
Dental	84	7	120	7	1.4	10
Disability	4		4		1.0	17
Endocrine	2		3		1.5	8
Gastrointestinal	14		16		1.1	14
Genitourinary	11		16		1.5	8
Health Maintenance	297	2	510	2	1.7	5
Kidney	3		4		1.3	11
Musculoskeletal	32	9	41	9	1.3	11
Neurological	9		14		1.6	7
No Prob/Screen	108	5	121	6	1.1	14
Nutrition	61	8	113	8	1.9	3
Respiratory	165	3	343	3	2.1	2
Skin	136	4	239	4	1.8	4
Social Issue	335	1	561	1	1.7	5
Substance Related	15	10	17	10	1.1	14
Trauma	5		6		1.2	13
Mental Health	97	6	221	5	2.3	1
Anxiety	12		14		1.2	
Depression	21		51		2.4	
Mental Health-Other	80		156		2.0	
Other	294		599		2.0	
Sign/Symptom	362		685		1.9	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	1		1		1.0	17
Dental	84	7	120	7	1.4	11
Disability	8		8		1.0	17
Endocrine	2		3		1.5	9
Gastrointestinal	14		16		1.1	16
Genitourinary	11		16		1.5	9
Health Maintenance	299	2	513	2	1.7	6
Kidney	3		4		1.3	12
Musculoskeletal	32	9	41	9	1.3	12
Neurological	9		14		1.6	7
No Prob/Screen	125	6	147	6	1.2	14
Nutrition	61	8	113	8	1.9	4
Respiratory	165	3	343	4	2.1	2
Skin	136	5	239	5	1.8	5
Social Issue	419	1	859	1	2.1	2
Substance Related	17		20		1.2	14
Trauma	24	10	39	10	1.6	7
Mental Health	148	4	384	3	2.6	1
Anxiety	28		53		1.9	
Depression	31		68		2.2	
Mental Health-Other	122		259		2.1	
Psychotic	3		4		1.3	
Other	315		630		2.0	
Sign/Symptom	420		848		2.0	

Adults in Families -- 2004 Users With Given Problem

(A user may have more than one problem)

1,131 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	86	5	288	3	3.3	2
Dental	90	4	127	7	1.4	11
Disability	19		26		1.4	11
Endocrine	53		180	5	3.4	1
Gastrointestinal	18		21		1.2	17
Genitourinary	43		63		1.5	10
Health Maintenance	63	8	87		1.4	11
Immune	3		7		2.3	4
Kidney	3		3		1.0	19
Musculoskeletal	131	3	240	4	1.8	8
Neurological	11		13		1.2	17
No Prob/Screen	65	7	93	9	1.4	11
Nutrition	54	10	91	10	1.7	9
Respiratory	82	6	156	6	1.9	7
Skin	63	8	91	10	1.4	11
Social Issue	378	1	854	1	2.3	4
Substance Related	51		101	8	2.0	6
Trauma	11		15		1.4	11
Mental Health	239	2	728	2	3.0	3
Anxiety	81		155		1.9	
Depression	134		341		2.5	
Mental Health-Other	124		232		1.9	
Other	304		678		2.2	
Sign/Symptom	317		686		2.2	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	88	7	291	4	3.3	4
Dental	92	6	129	10	1.4	13
Disability	27		35		1.3	16
Endocrine	56		186	7	3.3	4
Gastrointestinal	18		21		1.2	17
Genitourinary	43		63		1.5	12
Health Maintenance	64	10	90		1.4	13
Immune	3		7		2.3	6
Kidney	3		3		1.0	19
Musculoskeletal	135	5	246	5	1.8	9
Neurological	11		13		1.2	17
No Prob/Screen	140	4	238	6	1.7	10
Nutrition	54		91		1.7	10
Respiratory	86	8	161	8	1.9	8
Skin	64	10	92		1.4	13
Social Issue	866	1	3,327	1	3.8	3
Substance Related	175	3	713	3	4.1	2
Trauma	65	9	152	9	2.3	6
Mental Health	424	2	1,797	2	4.2	1
Anxiety	189		472		2.5	
Depression	273		782		2.9	
Mental Health-Other	214		530		2.5	
Psychotic	9		13		1.4	
Other	379		893		2.4	
Sign/Symptom	457		1,174		2.6	

Unattached Youth -- 2004 Users With Given Problem

(A user may have more than one problem)
969 Unattached Youth

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	2		2		1.0	15
Dental	18		21		1.2	13
Disability	2		2		1.0	15
Endocrine	6		32		5.3	1
Gastrointestinal	24	10	38	10	1.6	7
Genitourinary	119	8	192	9	1.6	7
Health Maintenance	331	1	536	1	1.6	7
Immune	1		1		1.0	15
Kidney	3		3		1.0	15
Musculoskeletal	170	7	303	6	1.8	4
Neurological	9		10		1.1	14
No Prob/Screen	276	2	421	3	1.5	10
Nutrition	22		29		1.3	11
Respiratory	210	3	387	4	1.8	4
Skin	207	4	352	5	1.7	6
Social Issue	180	6	233	7	1.3	11
Substance Related	110	9	207	8	1.9	3
Trauma	4		4		1.0	15
Mental Health	206	5	491	2	2.4	2
Anxiety	50		90		1.8	
Depression	93		166		1.8	
Mental Health-Other	128		228		1.8	
Psychotic	2		7		3.5	
Other	490		1,029		2.1	
Sign/Symptom	348		586		1.7	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	2		2		1.0	17
Dental	18		21		1.2	15
Disability	7		14		2.0	6
Endocrine	6		33		5.5	1
Gastrointestinal	24	10	40	10	1.7	8
Genitourinary	124	9	207	9	1.7	8
Health Maintenance	334	2	546	3	1.6	11
Immune	1		1		1.0	17
Kidney	3		3		1.0	17
Musculoskeletal	202	7	486	4	2.4	3
Neurological	9		10		1.1	16
No Prob/Screen	285	4	463	5	1.6	11
Nutrition	22		31		1.4	14
Respiratory	216	5	411	7	1.9	7
Skin	212	6	366	8	1.7	8
Social Issue	336	1	698	2	2.1	5
Substance Related	200	8	457	6	2.3	4
Trauma	16		26		1.6	11
Mental Health	297	3	1,500	1	5.1	2
Anxiety	88		429		4.9	
Depression	154		402		2.6	
Mental Health-Other	212		645		3.0	
Psychotic	13		24		1.8	
Other	551		1,494		2.7	
Sign/Symptom	419		895		2.1	

Appendix C

Health Care for the Homeless Network Advisory Planning Council

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